The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at 1-844-282-3025 or visit us on the web at <u>https://www.christushealthplan.org/</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>http://www.healthcare.gov/sbc-glossary</u> or call 1-844-282-3025 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.christushealthplan.org/ find-a-provider or call 1-844-282- 3025 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance</u> <u>billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No charge	Not covered	Including office services, other than those specifically shown below.
If you visit a health care provider's office or	<u>Specialist</u> visit	No charge	Not covered	Including office services, other than those specifically shown below.
clinic	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	Diagnostic test (x-ray, blood work)	No charge	Not covered	None.
lf you have a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need drugs to treat your illness or condition More information about <u>prescription drug</u> <u>coverage</u> is available at <u>www.christushealthplan.</u> <u>org</u>	Preferred generic drugs	No charge	Not covered	Cost sharing for a 90-day supply by mail order
	Non-preferred generic drugs	No charge	Not covered	is triple the <u>cost sharing</u> for a standard 30-day supply. <u>Cost sharing</u> for <u>specialty drugs</u> is limited to \$150 per prescription for a standard 30-day supply. Prescriptions for birth control are not subject to <u>deductible</u> , and do not have
	Preferred brand drugs	No charge	Not covered	
	Non-preferred brand drugs	No charge	Not covered	a <u>copayment</u> .
	Specialty drugs	No charge	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
surgery	Physician/surgeon fees	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need in the	Emergency room care	No charge	No charge	
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	None.
	Urgent care	No charge	Not covered	

CHPLA21AI0

		What You Will Pay			
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
lf you have a hospital	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
stay	Physician/surgeon fees	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	MH/SUD office visits are subject to the listed cost sharing, while MH/SUD facility outpatient treatments are subject to the outpatient facility coinsurance. Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Inpatient services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).	
lf you are pregnant	Childbirth/delivery professional services	No charge	Not covered	None.	
	Childbirth/delivery facility services	No charge	Not covered	Preauthorization is required for inpatient care, except for: (1) forty-eight (48) hours of Inpatient care following an uncomplicated vaginal delivery or ninety-six (96) hours of Inpatient care following an uncomplicated Cesarean section or (2) Post-Partum Care. If you don't get <u>preauthorization</u> , benefits will be denied.	

CHPLA21AI0

		What You Will Pay			
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Home health care	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Rehabilitation services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
If you need help recovering or have other special health needs	Habilitation services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Skilled nursing care	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Durable medical equipment	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
	Hospice services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied.	
lf your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam per year.	
	Children's glasses	No charge	Not covered	Limited to one pair of glasses per year.	
	Children's dental check-up	No charge	Not covered	Limited to one visit per 6 months.	

CHPLA21AI0

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
Abortion	Dental Care – Basic and Major (Children) Orthodontia			
Acupuncture	Infertility Treatment Routine eye care for adults			
 Bariatric Surgery 	Long-term Care Routine foot care for diabetic members			
Cosmetic Surgery	Non-emergency care when traveling outside the Treatment for temporomandibular joint disorders			
 Dental Care (Adult) 	United States			
Other Covered Services (Limitation	may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
Chiropractic care	 Hearing aids (1 hearing aid in each ear every 3 Private-duty nursing 			
	years)			

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: CHRISTUS Health Plan Customer Service at 1-844-282-3025; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace. For more information about the Marketplace. For more information about the Marketplace. Poc. Box of the second second

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: CHRISTUS Health Plan Customer Service at 1-844-282-3025 or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-282-3025 (TTY: 1-800-735-2989).

Vietnamese: CHÚÝ: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-282-3025 (TTY: 1-800-735-2989). Chinese: 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電1-844-282-3025 (TTY1-800-735-2989)。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-282-3025 (TTY: 1-800-735-2989)번으로 전화해 주십시오.

Arabic: والبكم الصم هاتف رقم) 2025-3022 1-844 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا ملحوظة : 1-800-735-2989). CHPLA21AIO

. (TTY: 1-800-735-2989). الحبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں :Urdu

Tagalog : PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-282-3025 (TTY: 1-800-735-2989).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-282-3025 (ATS : 1-800-735-2989).

. (TTY: 1-800-735-2989) پاسخ هستند شما دسترس در کنند، می صحبت رایگان زبان، کمک خدمات فارسی، شما اگر Persian:

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-282-3025 (TTY: 1-800-735-2989).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-282-3025 (телетайп: 1-800-735-2989).

Japanese: 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-844-282-3025(TTY: 1-800-735-2989)まで、お電話 にてご連絡ください。

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,

ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-282-3025 (TTY: 1-800-735-2989).

Hindi: हंद: सावधानी: यदि आप हिंदी बोलते हैं, तो आप मुफ्त भाषा सहायता सेवाओं से लाभ उठा सकते हैं। 1-844-282-3025 पर कॉल करें (टीटीवी: 1-800-735-2989)

Gujarati: જરાત: સાવધાન: જો તમે ગુજરાતી બોલતા હોવ તો, તમે મફત ભાષા સહાય સેવાઓમાંથી લાભ મેળવી શકો છો. 1-844-282-3025 પર કૉલ કરો (TTY: 1-800-735-2989)

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

\$0 \$0

\$0

0%

Peg is Having a Baby (9 months of in-network pre-natal care and a

\$0

\$0 \$0

0%

hospital delivery)

The <u>plan's</u> overall <u>deductible</u>
Specialist copayment
Hospital (facility) copayment
Other coinsurance

This EXAMPLE event includes services like:

<u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-
controlled condition)

The plan's overall deductible
Specialist copayment
Hospital (facility) copayment
Other coinsurance
This EXAMPLE event includes convised like

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)

	Total Example Cost	\$5,600
--	--------------------	---------

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$0
Specialist copayment	\$0
Hospital (facility) copayment	\$0
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.